DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445415	A. BUILDING _____ B. WING _____	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, FARRAGUT	120 CAVETT HILL LANE KNOXVILLE, TN 37922

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	A. Resident #9 & #14 comprehensive assissment did not include periodic side rail assissments. A current side rail assessment was provided on Resident #9 & #14 on 10-24-11 by , RN. B. Allin house residents were reviewed on 11-9-11 utilizing the side rail assessment form by , RN. No adverse outcomes were reported for use of side rails in the facility. The nursing staff was inserviced on 11-1-2011 & 11-3-2011 regarding comprehensive assessments/ side rail assessments by DON. Content of inservice included side rail assessment on admission, side rail orders and periodic assissment with COS, quarterly and annual MDS. C. Nursing staff was inserviced by , DOn on 11-1-2011 & 11-3-11 through sharing of survey results and plan of correction regarding process changes for side rail assessments and use of side rails.	11/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/2/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to perform periodic assessments for the use of side rails for two (#9, #14) of three residents reviewed from twenty-eight residents using siderails. The findings included: Resident # 9 was readmitted to the facility on September 21, 2011, with diagnoses including status post Left Total Hip Arthroplasty, status post Revision of Left Total Hip Arthroplasty, Atrial Fibrillation, Coumadin Therapy, and Sick Sinus Syndrome with Permanent Pacemaker. Review of the Minimum Data Set (MDS) dated September 28, 2011, revealed the resident required extensive assistance with bed mobility, transfers, and moderate to extensive assistance with activities of daily living. Medical record review of Physician's orders dated September 21, 2011-December 20, 2011, revealed "...Side rail use is optional per patient preference. This is not a restraint..." Continued medical record review revealed no documentation of a side rail assessment. Review of facility policy "Proper Use of Side Rails" revealed, "...3. An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for	F 272	D. Quality assurance will audit and monitor every 3 months X 2 for compliance and PRN for use of resident side rail assessment form on admission, quarterly, COS, and annually to comply with F-272 guidelines.	

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F 272	Continued From page 2 mobility or transfer, an assessment will include a review of the resident's bed mobility and ability to change positions, transfer to and from bed or chair, and to stand and toilet..." Observation of the resident on October 18, 2011, at 7:30 a.m.; and October 20, 2011, at 7:30 a.m., revealed elevated bilateral upper half side rails, when the resident was in bed. Continued observation on October 18, 2011, at 10:30 a.m., revealed the rails were lowered when the resident was not in bed. Interview with the resident on October 20, 2011, at 3:50 p.m., at the second floor nurse's station, revealed the resident used the rails as an assistive device. "...I use them to help me move in the bed at night, they let them down during the day..." Interview with the Director of Nursing, on October 20, 2011, at 1:50 p.m., in the conference room, revealed "...On admission, the admission nurse does an initial side rail assessment; the results are entered into the I-MAR (electronic medical documentation) and printed as a physician's order. There is no assessment form retained in the chart. Assessments are done on admission, readmission, and at a significant change of the resident. There are no routine reassessments..." Interview with the Charge Nurse Registered Nurse (RN #1) on October 20, 2011, at 3:50 p.m., at the second floor nurses station, confirmed there was no documentation the side rail assessments had been completed.	F 272		

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F 272	Continued From page 3 Resident #14 was admitted to the facility on March 28, 2001, with diagnoses including Multiple Sclerosis, Depression, Anxiety, Agitation, and Hallucinations. Review of the Minimum Data Set dated July 6, 2011, revealed the resident was totally dependent on the staff for all activities of daily living. Medical record review of the Weekly Nursing Summaries for July-October 2011, revealed the resident was "totally dependent" on the staff for "moving to and from lying position, turning side to side, and positioning while in bed." Medical record review revealed no curent documentation of assessment for the use of side rails. Observation on October 20, 2011, at 7:25 a.m., revealed the resident in bed with both of the upper side rails in the raised positon. Interview with the second floor Charge Nurse (Registered Nurse #1) on October 20, 2011, at 8:03 a.m., revealed the resident liked to have the side rails in the raised position, and verified the rails "could be restrictive if the resident wanted to extend or straighten the arm." Continued interview confirmed the facility failed to assess for the use of side rails.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		11/11/11

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F 279	Continued From page 4 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to develop a care plan to address the use of side rails for one (# 9) of three residents reviewed of twenty-eight residents using side rails; and failed to develop a care plan to address the use of the psychoactive drug Seroquel for one (#14) of four residents reviewed for the use of psychotropic medications of thirty-three residents in Stage 2. The findings included: Resident # 9 was readmitted to the facility on September 21, 2011, with diagnoses including status post Left Total Hip Arthroplasty, status post	F 279	A. Resident #9 comprehensive care plan did not include use of siderails. The care plan was updated on 10-24-11 to include use of side rails as an assistive device per patient request by , RN. Resident #14 comprehensive care plan did not include use of antipsychotic medication. The care plan was updated on 10-24-11 to include use of antipsychotic drugs with monitoring of toward and untoward effects by RN. B. Starting on 11-9-11 all residents care plans will include use of side rails per assessment outcome by the care plan coordinators or any licensed nurse. No adverse outcomes were found from omission of side rails to the care plans. All residents receiving antipsychotic drugs care plans were reviewed by the licensed nursing staff and found to be in compliance so no adverse outcomes were found from omission of antipsychotic drugs to the care plans. The nursing staff was	

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F 279	Continued From page 5 Revision of Left Total Hip Arthroplasty, Atrial Fibrillation, Coumadin Therapy, and Sick Sinus Syndrome with Permanent Pacemaker. Medical record review of Physician's orders dated September 21, 2011-December 20, 2011, revealed "...Side rail use is optional per patient preference. This is not a restraint..." Medical record review of the Care Plan dated October 11, 2011, revealed no documentation of the use of side rails as an assistive device. Observation of the resident on October 18, 2011, at 7:30 a.m., and October 20, 2011, at 7:30 a.m., revealed elevated bilateral upper half side rails, when the resident was in the bed. Continued observation on October 18, 2011, at 10:30 a.m., revealed the rails were lowered when the resident was not in the bed. Review of facility policy "Proper Use of Side Rails" revealed, "...4. The use of side rails as an assistive device will be addressed in the resident care plan..." Interview with the resident on October 20, 2011, at 3:50 p.m., at the second floor nurse's station revealed the resident used the rails as an assistive device "...I use them to help me move in the bed at night, they let them down during the day..." Interview with Registered Nurse (RN #1) on October 20, 2011, at 4:00 p.m., in the second floor nurses station, confirmed the use of side rails as an assistive device was not addressed on the resident's Care Plan.	F 279	inserviced by the DoN on 11-1-2011 & 11-3-2011 regarding updating the care plans with use of side rails if needed and use of antipsychotic drugs. C. Nursing staff was inserviced by ,DON on 11-1-2011 & 11-3-11 through sharing of survey results and the plan of correction regarding updating comprehensive care plans as necessary. D. Quality assurance will audit and monitor every 3 months X 2 and PRN for compliance to ensure that side rails if needed and antipsychotic drugs are care planned to comply with F-279 guidelines.	

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F 279	Continued From page 6 Resident #14 was admitted to the facility on March 28, 2001, with diagnoses including Multiple Sclerosis, Depression, Anxiety, Agitation, and Hallucinations. Observation on October 20, 2011, at 10:35 a.m., revealed the resident pleasant and in the reclining Geri-chair in the room. Medical record review revealed a physician's order written September 29, 2011, for Seroquel 12.5 milligrams (an anti-psychotic) every evening. Review of the medication administration record revealed the medication was administered as ordered. Review of the current care plan revealed no documentation of the use of the drug Seroquel. Interview at the 2nd floor nurses' station with Registered Nurse (RN) #1 on October 20, 2011, at 9:51 a.m., confirmed the facility failed to develop a care plan for the use of the psychoactive drug Seroquel.	F 279		
F 334 SS=D	483.25(h) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334		11/11/11

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F 334	Continued From page 7 immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that – (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:	F 334	A. Resident #56 received the flu immunization on 10-20-11 by ,RN and was monitored throughout the 48 hours post immunization by nursing staff with the omission of one temperature on 7p-7a on 10-20-11. During this monitoring period no negative outcomes were found. B. As of 11-7-11 all residents who receive the flu immunization in the facility will have their temperature monitored each shift X 48 hours per policy. No adverse outcomes were found or reported related to administration of flu immunization and no febrile episodes have been reported post immunization. The nursing staff was inserviced by DON on 11-1-2011 & 11-3-2011 regarding the "Influenza and Pneumococcal Immunization Record". This includes immunization history, education provided, administration record and post immunization monitoring. C. Nursing staff was inserviced by DON on	

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F 334	Continued From page 8 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to ensure the medical record included documentation the resident was provided education regarding the benefit and potential side effects of the influenza immunization for one (#56); and failed to obtain the temperature following immunization for one (#56) of five residents reviewed for immunization. The findings included: Resident #56 was admitted to the facility on September 13, 2011, with diagnoses including Rehabilitation after Knee surgery. Medical record review revealed the resident received the influenza immunization on October	F 334	11-1-2011 & 11-3-11 through sharing of survey results and plan of correction regarding immunization protocol. D. Quality assurance will audit and monitor every 3 months X 2 and PRN for compliance to ensure post immunization temperatures are being taken and documented per policy to comply with F-334 guidelines.	

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F 334	Continued From page 9 20, 2011, at 12:20 p.m. Medical record review revealed no documentation of education regarding the benefit and potential side effects of the influenza immunization. Interview with the Infection Control Officer and the Director of Nursing in the second floor activity room on October 21, 2011, at 8:51 a.m., confirmed the facility failed to document education regarding the immunization. Review of the facility policy (un-numbered) revised October 1, 2008, titled Infection Control Manual, revealed, "...The following 48 hours after vaccination Nursing is responsible for checking patient temperature every shift." (The facility nursing shifts are 12 hours from 7-7.) Review of the medical record revealed no documentation the resident's temperature was obtained after the injection until the 7AM shift on October 21, 2011. Interview with the Infection Control Officer and the Director of Nursing in the second floor activity room on October 21, 2011, at 8:51 a.m., confirmed the facility failed to follow the facility policy to obtain temperature on residents after the immunization.	F 334		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		11/11/11

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F 431	Continued From page 10 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure stock medications assigned for resident use were maintained within the manufacturer's expiration date in one of two medication rooms. The findings included:	F 431	A. On 10-17-11 the facility disposed of the expired acetaminophen suppositories immediately. Replacement suppositories were ordered on 10-17-11 and expiration date was reviewed. The consultant pharmacist, was notified by ,DON of this finding on 10-20-11. B. No adverse outcomes were found related to expiration of acetaminophen suppositories. The nursing staff was inserviced by ,DON on 11-1-2011 & 11-3-2011 regarding checking for expiration dates on drugs and the consultant pharmacist was inserviced on 10-28-11. C. Nursing staff was inserviced by ,DON on 11-1-2011 through 11-3-11 through sharing of survey results and the plan of correction to checking for expired drugs. D. Quality assurance willaudit every 3 months X 2 and PRN for compliance and the consultant pharmacist will monitor every month for compliance of medication expiration dates for accuracy	

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F 431	Continued From page 11 Observation with the Charge Nurse on October 17, 2011, at 10:00 a.m., in the first floor medication room revealed thirty-five, 650 milligram, acetaminophen suppositories designated as stock medications for resident use were out of date. Continued observation revealed the expiration date on the suppository package was March 2011. Interview with the Charge Nurse on October 17, 2011, at 10:00 a.m., in the first floor medication room confirmed the medication had expired.	F 431	and to comply with F-431 guidelines.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		11/11/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445416	A. BUILDING _____ B. WING _____	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, FARRAGUT	120 CAVETT HILL LANE KNOXVILLE, TN 37922

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to follow infection control guidelines for the use of oxygen equipment, for one resident (#9) of forty residents observed, and failed to administer medications in a sanitary manner, for one resident (#539) of ten residents observed for medication administration. The findings included: Resident # 9 was readmitted to the facility on September 21, 2011, with diagnoses including status post Left Total Hip Arthroplasty, status post Revision of Left Total Hip Arthroplasty, Atrial Fibrillation, Coumadin Therapy, and Sick Sinus Syndrome with Permanent Pacemaker. Observation on October 18, 2011, at 10:30 a.m., in the resident's room, revealed an oxygen concentrator. The humidity bottle was dated '9/26/11.' The nasal cannula tubing was coiled	F 441	A. Resident #9 oxygen's tubing/nasal cannula and humidification bottle was immediately replaced on 10-18-11 by .RN and labeled according to NHC's Aerosol policy.LPN was informed and reeducated to correct medication procedure and infection control guidelines at time of occurrence by , RN-CC and again on 10-21-11 by , DON. B. These two occurrences were reported to the Infection Control Team on 10-24-11. The nursing staff was inserviced by DON on 11-1-2011 & 11-3-2011 regarding aerosol policy and infection control guidelines related to medication administration. No adverse outcomes were found related to oxygen tubing and infection control violation during medication administration. The nursing staff was also inserviced on 11-1-11 & 11-3-11 by RN, Infection Control Nurse regarding infection control practices.	

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	445415	A. BUILDING _____ B. WING _____	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, FARRAGUT	120 CAVETT HILL LANE KNOXVILLE, TN 37922

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 around the top of the concentrator and was not covered or labeled with a date it was changed. Review of facility policy "Respiratory Services Program-Oxygen delivered by Nasal Cannula", revealed "...Infection Control: 1. Change tubing and cannula every 7 days. Label each tubing with date, time and your initials. 3. Change humidifier when empty or at least weekly..." Interview with the resident on October 18, 2011, at 10:30 a.m., in the resident's room, revealed "...I use the portable and that machine. I've used that (the concentrator) a couple of times in the past two weeks..." Interview with Registered Nurse (RN) #1 on October 20, 2011, at 10:15 a.m., in the resident's room, confirmed the oxygen concentrator humidifier and tubing had not been changed according to infection control policy. Observation on October 17, 2011, at 9:00 a.m., revealed Licensed Practical Nurse (LPN) #1 prepared medications for resident #539. Continued observation revealed LPN #1 dropped one tablet of Metoprolol 50 mg (milligram) and one tablet of Spironolactone 25 mg onto the unclean medication cart; picked up each pill with the bare fingers, and placed them into the medication cup. Continued observation revealed LPN #1 continued to add the other clean medications to the unclean medications in the medication cup. Continued observation revealed LPN #1 administered the unclean medications to resident #539.	F 441	C. Nursing staff was inserviced by DON on 11-1-2011 & 11-3-11 through sharing of survey results and the plan of correction regarding aerosol policy, infection control guidelines and medication administration guidelines. D. Quality assurance will audit and monitor compliance with aerosol policy every 3 months X 2 and PRN. The DON/ADON/ or designated appointee will monitor medication administration and compliance with infection control practices every 3 months X 2 and PRN. The consultant pharmacist will monitor compliance monthly X 3 then biannually during medication pass observation to comply with F-441 guidelines.	